		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044982

Facility Name: LaGrange Rehab Healthcare Center

Address: 339 South Ninth Avenue (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 354-4660 **Fax #** (708) 354-7566

IDPA ID Number: 36-4379326

Date of Initial License for Current Owners: 7/15/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Maureen Westmiller **Telephone Number:** (505) 366-5211

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/15/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Robin Underhill
(Title) Chief Operating Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	40,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	40,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,968	3,659	1,995	31,622	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,968	3,659	1,995	31,622	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.89%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/15/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/15/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 43 and days of care provided 3,859

Medicare Intermediary Trailblazers

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	149,533	12,390	2,164	164,087	(1,005)	163,082		163,082			1
2	Food Purchase		132,052		132,052		132,052		132,052			2
3	Housekeeping	101,592	16,825		118,417		118,417		118,417			3
4	Laundry	58,072	21,130		79,202		79,202	(2,390)	76,812			4
5	Heat and Other Utilities			154,508	154,508		154,508		154,508			5
6	Maintenance	54,451	7,249	42,487	104,187	2,135	106,322		106,322			6
7	Other (specify):*											7
8	**TOTAL General Services**	363,648	189,646	199,159	752,453	1,130	753,583	(2,390)	751,193			8
	B. Health Care and Programs											
9	Medical Director			15,700	15,700		15,700		15,700			9
10	Nursing and Medical Records	1,557,643	43,474	6,520	1,607,637	4,135	1,611,772	(480)	1,611,292			10
10a	Therapy	152,041	22,164	24,307	198,512		198,512		198,512			10a
11	Activities	42,669	6,621	3,759	53,049	(2,258)	50,791		50,791			11
12	Social Services	42,200			42,200		42,200		42,200			12
13	Nurse Aide Training	24,190		1,880	26,070		26,070		26,070			13
14	Program Transportation											14
15	Other (specify):* Rehab & Area Dir			9,631	9,631		9,631	(13,420)	(3,789)			15
16	**TOTAL Health Care and Programs**	1,818,743	72,259	61,797	1,952,799	1,877	1,954,676	(13,900)	1,940,776			16
	C. General Administration											
17	Administrative	126,359			126,359	(48,068)	78,291	(20,692)	57,599			17
18	Directors Fees											18
19	Professional Services			57,256	57,256		57,256	(29,173)	28,083			19
20	Dues, Fees, Subscriptions & Promotions			15,206	15,206	(1,407)	13,799	(4,476)	9,323			20
21	Clerical & General Office Expenses	17,296	8,079	26,116	51,491	45,248	96,739	(510)	96,229			21
22	Employee Benefits & Payroll Taxes			412,688	412,688		412,688		412,688			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,052	4,052	(789)	3,263	(2,959)	304			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,822	62,822		62,822		62,822			26
27	Other (specify):* See 4.4			338,235	338,235		338,235	(107,804)	230,431			27
28	**TOTAL General Administration**	143,655	8,079	916,375	1,068,109	(5,016)	1,063,093	(165,614)	897,479			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,326,046	269,984	1,177,331	3,773,361	(2,009)	3,771,352	(181,904)	3,589,448			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LaGrange Rehab Healthcare Center #0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							588	588			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,663	10,663		10,663		10,663			32
33	Real Estate Taxes			222,975	222,975		222,975	(40,150)	182,825			33
34	Rent-Facility & Grounds			617,009	617,009		617,009		617,009			34
35	Rent-Equipment & Vehicles			42,190	42,190	(870)	41,320		41,320			35
36	Other (specify):*											36
37	**TOTAL Ownership**			892,837	892,837	(870)	891,967	(39,562)	852,405			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,594	3,337	96,931		96,931		96,931			39
40	Barber and Beauty Shops			1,277	1,277	2,879	4,156		4,156			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,306	61,306		61,306	(406)	60,900			42
43	Other (specify):* See 4.4			2,752	2,752		2,752		2,752			43
44	**TOTAL Special Cost Centers**		93,594	68,672	162,266	2,879	165,145	(406)	164,739			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,326,046	363,578	2,138,840	4,828,464		4,828,464	(221,872)	4,606,592			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(25,000)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,777)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(115,683)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (222,460)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule **See 5.1**	588	30	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 588		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (221,872)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LaGrange Rehab Healthcare Center

ID# 0044982

Report Period Beginning: 7/15/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Accounting/Audit	$ (2,625)	19	1
2	Employee Relations		20	2
3	Marketing & Public Relations		20	3
4	Late Fees	(235)	27	4
5	Legal Expense -accrual only	(26,548)	19	5
6	Management Fees		27	6
7	Resident Settlement	(792)	27	7
8	Laundry Income	(2,390)	4	8
9	Vending Income		6	9
10	Barber & Beauty Income	(3,789)	15	10
11	Interest Income		32	11
12	Other Income	(3)	21	12
13				13
14	Adj Provider tax to $1.50 x 40,600 from 61,306	(406)	42	14
15	Adj Real Estate taxes to our portion of amount pd	(40,150)	33	15
16	($337,524 divided by 12 x 6 1/12 months =182,825)			16
17	Reverse Accrual for Registry Nusring	(480)	10	17
18	Marketing Salaries coded to Administrator	(20,005)	17	18
19	Marketing Benefits coded to Administrator	(687)	17	19
20	Chamber of Commerce coded to Dues	(575)	20	20
21	Vending Fee-coded to Dues	(120)	20	21
22	Marketing expense	(3,781)	20	22
23	Bank Charges	(507)	21	23
24	Travel & Entertainment-out of state	(2,959)	24	24
25	Rehab Consulting - estimate	(9,631)	15	25
26				26
27				27
28				28
29				29
30				30
31				31
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85				85
86				86
87				87
88				88
89				89
90	**Total**	(115,683)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2,390)	0	0	0	0	0	0	0	0	0	0	(2,390)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,390)	0	0	0	0	0	0	0	0	0	0	(2,390)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(480)	0	0	0	0	0	0	0	0	0	0	(480)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(13,420)	0	0	0	0	0	0	0	0	0	0	(13,420)	15
16	**TOTAL Health Care and Programs**	(13,900)	0	0	0	0	0	0	0	0	0	0	(13,900)	16
	C. General Administration													
17	Administrative	(20,692)	0	0	0	0	0	0	0	0	0	0	(20,692)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(29,173)	0	0	0	0	0	0	0	0	0	0	(29,173)	19
20	Fees, Subscriptions & Promotions	(4,476)	0	0	0	0	0	0	0	0	0	0	(4,476)	20
21	Clerical & General Office Expenses	(510)	0	0	0	0	0	0	0	0	0	0	(510)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,959)	0	0	0	0	0	0	0	0	0	0	(2,959)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(107,804)	0	0	0	0	0	0	0	0	0	0	(107,804)	27
28	**TOTAL General Administration**	(165,614)	0	0	0	0	0	0	0	0	0	0	(165,614)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(181,904)	0	0	0	0	0	0	0	0	0	0	(181,904)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **LaGrange Rehab Healthcare Center** **#** **0044982** **Report Period Beginning:** **7/15/00** **Ending:** **12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	588	0	0	0	0	0	0	0	0	0	0	588	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(40,150)	0	0	0	0	0	0	0	0	0	0	(40,150)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(39,562)	0	0	0	0	0	0	0	0	0	0	(39,562)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	(406)	0	0	0	0	0	0	0	0	0	0	(406)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(406)	0	0	0	0	0	0	0	0	0	0	(406)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(221,872)	0	0	0	0	0	0	0	0	0	0	(221,872)	45

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Ballantrae Illinois, LLC	100	Note: Per State, this facility is deemed not related, therefore, I have not listed our other Nurisng Homes				NF
		Note: We sublease from related party, however, the original owners are not related to our sublessor				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V				We sublease from related party, however, the original owners				2
3	V				are not related to our sublessor.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V		We sublease from related party						16
17	V		however, the owners of the property						17
18	V		are not related to our sublessor.						18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Ballantrae Healthcare
Street Address: 1128 Pennsylvania Suite #100
City / State / Zip Code: Albuquerque, NM 87110
Phone Number: (505)-366-5200
Fax Number: (505)366-5204

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1			Days			$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Elite Care Company		X	Security Deposit	$5,059.00	7/15/00	$ 182,797	$ 182,797	6/1/05	10.0000	$ 10,663	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$5,059.00		$ 182,797	$ 182,797			$ 10,663	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 182,797	$ 182,797			$ 10,663	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	222,975	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	182,825	2
3. Under or (over) accrual (line 2 minus line 1).	$	(40,150)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	222,975	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	182,825	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	336,977	8
	1996	377,941	9
	1997	364,054	10
	1998	352,925	11
	1999	182,825	12

Note: Chow took place 7/15/00, therefore taxes are prorated to $337,527 divided by 12 x 6 1/2 months = $182,825

Please note that the amount used on the Change of ownership report is unknown, therefore, for the purpose of this report we are reporting the amount paid with no accrual of $182,825

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,148 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 2,004,509	$	$ 109,630	$ 109,630		$ 569,961	37
38	Current Year Purchases	15,572		588	588	5	588	38
39	Fully Depreciated Assets							39
40	SEE 5.1							40
41	TOTALS	$ 2,020,081	$	$ 110,218	$ 110,218		$ 570,549	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,020,081	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 110,218	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 110,218	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 570,549	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elite Care Corporation

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A	203	7/15/00	$ 617,009	6	5	3
4	Additions							4
5	for period 7/15/00 - 1/31/01							5
6								6
7	TOTAL		203		$ 617,009 **			7

10. Effective dates of current rental agreement:
Beginning 7/15/00
Ending 1/31/06

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 1118712
13.	/2002	$ 1141092
14.	/2003	$ 1163916

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 41,320 Description: See 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO
See Attached 15.1

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.
TRAINING FROM OTHER SOURCES IN THEIR AREA.

2. CLASSROOM PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	line 10a col 1,2,3	58	hrs	$ 1,549	893	$ 10,711	$ 349	951	$ 12,609	1
2	Licensed Speech and Language Development Therapist	line 10a col 1, 2, 3	468	hrs	21,842	62	930		530	22,772	2
3	Licensed Recreational Therapist	line 10a col 1, 2, 3	4601	hrs	77,482	249	10,149	19,139	4,850	106,770	3
4	Licensed Physical Therapist	line 10a col 1, 2, 3	1736	hrs	51,168	234	2,517	2,676	1,970	56,361	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts				60,757		60,757	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): See 16.1							32,837		32,837	13
14	TOTAL				$ 152,041	1,438	$ 24,307	$ 115,758	8,301	$ 292,106	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 **Report Period Beginning:** 7/15/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (146,309)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,451,110		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,070		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,312,871	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	12,075		15
16	Equipment, at Historical Cost	4,195		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	(1,291,311)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (1,275,041)	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 37,830	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 56,244	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,819		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,050		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,140		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,937		35
	Other Current Liabilities(specify):			
36	See 17.1	1,652		36
37	See 17.1	143,664		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 296,506	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	297,612		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 297,612	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 594,118	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (556,288)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 37,830	$	48

***(See instructions.)**

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(564,080)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Intercompany Transf to bal to equity**	1,481,900	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 917,820	17
	B. Transfers (Itemize):		
18	**Intercompany Transfer**	(1,474,108)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,474,108)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (556,288)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,128,656	1
2	Discounts and Allowances for all Levels	16,545	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,145,201	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	492,857	6
7	Oxygen	39,118	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 531,975	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,789	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	44,292	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,024	19
20	Radiology and X-Ray	2,045	20
21	Other Medical Services	173,327	21
22	Laundry	2,390	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 227,867	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See 19.1	(640,659)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (640,659)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,264,384	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	752,453	31
32	Health Care	1,952,799	32
33	General Administration	1,068,109	33
	B. Capital Expense		
34	Ownership	892,837	34
	C. Ancillary Expense		
35	Special Cost Centers	98,208	35
36	Provider Participation Fee	61,306	36
	D. Other Expenses (specify):		
37	Lab & Radiology	2,752	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,828,464	40
41	**Income before Income Taxes (line 30 minus line 40)****	(564,080)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (564,080)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	934	974	$ 29,041	$ 29.82	1
2	Assistant Director of Nursing	1,174	1,214	28,533	23.50	2
3	Registered Nurses	16,078	17,098	359,310	21.01	3
4	Licensed Practical Nurses	19,773	20,611	422,671	20.51	4
5	Nurse Aides & Orderlies	60,501	62,715	632,849	10.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,665	6,863	152,041	22.15	7
8	Rehab/Therapy Aides					8
9	Activity Director	4,596	4,868	42,669	8.77	9
10	Activity Assistants					10
11	Social Service Workers	2,582	2,645	42,200	15.95	11
12	Dietician	1,958	2,039	22,199	10.89	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,132	14,718	127,334	8.65	15
16	Dishwashers					16
17	Maintenance Workers	3,532	3,703	54,451	14.70	17
18	Housekeepers	11,983	12,439	101,592	8.17	18
19	Laundry	7,050	7,429	58,072	7.82	19
20	Administrator	1,330	1,408	57,599	40.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	738	774	17,296	22.35	23
24	Clerical	3,646	3,811	44,636	11.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,126	2,202	34,630	15.73	31
32	Other Health C: C/s, MDS, Mcd co	3,108	3,309	54,041	16.33	32
33	Other(specify) Training & Mark.	2,300	2,397	44,882	18.72	33
34	TOTAL (lines 1 - 33)	164,206	171,217	$ 2,326,046 *	$ 13.59	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	23	$ 1,023	line 1 col 3	35
36	Medical Director	mon. Fee	15,700	line 9 col. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	see below	6,040	line 10 col 3	39
40	Physical Therapy Consultant			line 10a col 3	40
41	Occupational Therapy Consultant			line 10a col 3	41
42	Respiratory Therapy Consultant			line 10a col 3	42
43	Speech Therapy Consultant			line 10 col 3	43
44	Activity Consultant	33	1,501	line 11 col. 3	44
45	Social Service Consultant			line 12 col. 3	45
46	Other(specify) Quality care conslt	16	624		46
47					47
48	line 39 -a fee of $5 per occupied bed				48
49	TOTAL (lines 35 - 48)	72	$ 24,888		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Jackie Lantern	Administrator	none	50,678
N. Simmons,J Ropp, , D. Strauss	Receptionist	none	15,529
T. Tran, D, Cerveny, J Salvatori	A/P, Payroll, Assist	none	29,107
Lorie Piper	Medicaid Coord	none	3,432
C. Maruna, M Mangrum, M. Straub	Marketing	none	20,692
Karen Scales	Administrator	none	6,921
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 126,359

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
SHS.com	Support for Kronos, Add-on	$ 13,765
Alliance	payroll processing	2,950
Accounting/Audit-accrual	Adj out col 7	2,625
Legal-accruals	Adj out col 7	26,548
Duane, Morris, & Heckscher		5,865
Duane, Morris, & Heckscher	legal svc-See 21.1	5,503
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 57,256

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,133
Unemployment Compensation Insurance	68,376
FICA Taxes	174,697
Employee Health Insurance	89,482
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 412,688

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 485
Advertising: Employee Recruitment	5,317
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA-Dues	3,346
Medicare system to verify elgibility-Ivans	175
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,323

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	304
(Alzheimer manager mileage , Diet	
Supervisor to get supplies, Bus. Officer	
Manager to train Zion NH, to get xmas gifts)	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 304

**See instructions.

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 Report Period Beginning: 7/15/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LaGrange Rehab Healthcare Center # 0044982 **Report Period Beginning:** 7/15/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois HC Assoc. $3,346

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,665 Line 4

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? X YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 60,900
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: Not performed before filing report The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.